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ABSTRACT

This document reports on the relationship between alcohol abuse and battering. Several theories, e.g., the disinhibition, disavowal, and learned behavior theories concerning the relationship between alcohol abuse and family violence are discussed. Literature on the relationship between alcohol and family violence is reviewed. Five intervention and treatment strategies are suggested and described. The relationship between alcohol abuse and victims of battering is discussed. The problem is described and literature reviewed. Seven recommendations for intervention and treatment are made, beginning with a better protocol for identifying affected victims of violence. A bibliography lists books on family violence, alcohol and family violence, and alcohol abuse and alcoholism, and this is followed by a list of 47 articles on similar topics. An analysis of local statistics on alcohol abuse and other drug abuse among victims and their abusers is included. Copies of two brochures on alcohol and drug abuse and battered women are included. (ABL)

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ALCOHOL AND FAMILY VIOLENCE

A Research Project for the

DIVISION OF COMMUNITY PROGRAMS

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PART I

ALCOHOL AND MEN WHO BATTER

PROBLEM STATEMENT

In the United States, it is estimated that 6-10 million women are physically abused by their intimate male partners yearly. Victims advocates and other helping agencies know that partner abuse is cyclic and may go on for years and years with increasing severity and frequency. In the last twenty years, the staff of shelters, social service agencies, and mental health centers have come to recognize the close relationship that alcohol abuse and partner abuse have. That relationship has been frequently reported in the literature about family violence for nearly twenty years. It has been studied, theorized, and analyzed, yet still is not completely understood.

It became clear to victims advocates early in the battered women's movement that alcohol was not the cause of woman battering. Shelter workers know that not every woman who was abused had an alcohol-abusing partner. Similarly, many victims reported that their abusers battered them when drinking and when not drinking. Early research done by experts like Lenore Walker and Richard Gelles confirmed that the correlation between alcohol and violence was not a causative but a contributing one.

It must be stated that research into family violence and research into the relationship between alcohol abuse and violence are in their infancy. There is not a great body of information upon which to draw conclusions and form effective intervention strategies. Much more work in these areas is being done and is needed before we clearly understand the dynamics between these two very complex personal and social problems.

Several theories have been postulated about the close connection between alcohol abuse and family violence, including:

1) The Disinhibition Theory

   This theory is that alcohol is known to lessen one's inhibitions and, therefore, a man's inhibition towards aggressive behavior is lessened when he consumes alcohol. Proposed by researcher Natalie Shainess in the early seventies, this theory is not supported by available evidence which shows that many alcoholics do not engage in aggressive behavior towards family members.

2) The Disavowal Theory

   Simply, this theory is that a man may beat his partner when drunk or drinking because he is aware, on some level, that he may not be held accountable for his behavior by his mate or by society because of diminished capacity.

3) The Learned Behavior Theory

Essentially, this theory is that batterers have learned through cultural or familial norms that drinking and violent behavior go together.

More recently, research has been focused on cultural and societal factors as causes of violence. Many now believe that external influences such as alcohol and other drug abuse have less significance.

What became very clear to early researchers was the close correlation of alcohol abuse and family violence. Several studies were done in the early seventies with results showing that alcohol consumption was involved with 44-93% of battering incidents. Psychologist Barbara Star says that more serious injuries occur when the assaultive partner has been drinking. Victims advocates concur with that finding. There is also some evidence that there is an increase in the incidence of alcohol abuse in relationships of more than 7 years' duration.[1]

There are significant similarities in the dynamics of battering and the dynamics of chemical dependency. The first of these is denial. Men who batter deny their behavior by blaming, by minimizing the amount of harm that they do, by rationalizing, and, not uncommonly, by relying on drunkenness to disavow the event entirely. Certainly, it is known that alcohol dependency is a disease of denial which is characterized by the abuser's pretense that his alcohol use causes no harm to himself or those around him.

Other similarities include:

1. Resolves conflict
2. Entire family system becomes dysfunctional
3. Children are at risk for becoming adult abusers
4. Blocks intimacy
5. Anesthetizes or removes feelings
6. Tolerated or learned

Both alcohol abuse and spouse abuse involve a progressive degeneration of the individuals and the families involved. Shelter workers see young children suffering from lack of trust, acting out behaviors (including violence against siblings, mothers, and others), poor self-esteem, and frequently growing up to be abusers or victims themselves. It is similarly known that children from alcoholic homes experience many of the same difficulties. Both kinds of abuse clearly continue from generation to generation.

While a great deal is known about successful treatment for alcohol abusers, treatment for batterers is in its infancy. Historically, there has been a feeling of territoriality between those who treat alcohol dependency and those who deal with battering. Part of that isolation has to do with the differences in approaches used by the

fields. Usually, there is a medical model in place for the treatment of chemical dependency, whereas the battered women's movement is rooted in a self-help model around social and political change. A conflict occurs when the chemical dependency treatment is a family systems model, which is usually the case, and the counselor seeks to involve the abuser's mate in counseling. Often such involvement can be extremely dangerous for the woman.

Clearly the two fields must come together to educate themselves about the dynamics of the respective problems and to then develop effective programs for intervention and treatment. As Janet Wright says, "It is important to approach family violence as a family systems problem and explore what that means. It is important to explore it as an addiction. And it is equally important to explore it as a societal problem."[2] The same can certainly be said for the relationship between substance abuse and family violence.

ALCOHOL AND MALE VIOLENCE: A REVIEW OF THE LITERATURE

Every major book written about family violence in the last twenty years, with the exception of one, mentions the close association of drinking behavior and/or alcoholism with male violence against women. The notable exception is a widely used handbook for battered women by Ginny NiCarthy.[3] Probably the first book written about spouse abuse was Erin Pizzey's book Scream Quietly or the Neighbors Will Hear, published in London in 1974.[4] Chiswick Women's Aid, the first shelter anywhere and the subject of Pizzey's book, opened its doors to hundreds of women who were being assaulted by their husbands, often after an evening at the local pub. Del Martin wrote the first American book about wife abuse, Battered Wives, which was published in 1976. In her book, Martin says, "Alcohol is one of several factors that often contribute to the circumstances in which marital violence occurs. It may be used as an excuse for violence and it may trigger arguments that lead to violence. But contrary to conventional beliefs, it is not necessarily a direct cause of violence, and therefore, does not help to explain the causes of wife-beating." She also indicates that, at that time, not much was known about the batterer and what information that was available came from victims.[5]

Lenore Walker, who published her widely acclaimed book, The Battered Woman, the same year, agrees with Martin. Her information about batterers came from conducting interviews with 120 victims of partner abuse. Over 50% of those individuals reported a relationship between alcohol and battering. Many thought that the violence was caused by their mate's drinking. Walker reports, however, that further analysis revealed that many men battered whether they were drinking or not. She learned, however, that the woman who suffered the most serious injuries were partnered with batterers who were consistent drinkers.[6]

As Dr. Walker's research continued, she founded the Battered Woman's Research Center. The results of her further study were published in August of 1984 in The Battered Woman Syndrome (New York: Springer Publishing Company). She reports that her sample of 403 battered women (203 of the sample also had been in a non-battering relationship so comparisons could be drawn) indicated a high frequency of alcohol abuse in both non-batterers (43%) and batterers (67%). She adds that those findings are consistent with those of other researchers. Cited are numerous studies, including one done by L.S. Labell, which found that 72% of the abusers of women seeking shelter were reported as having alcohol problems[7] and Maria Roy's study of 150 women who called the New York City Hotline which revealed alcohol or drug involvement in 85% of their violent relationships.[8]

Most significant is the discovery that alcohol abuse among batterers is probably not different from the rest of the population. Walker cites a 1970 study done by D. Calahan which indicated that 15% of the male population and 7-14% of the female population were alcohol abusing.[9] The sample of batterers and victims in Walker's study fell within that range.

In studying the relationship between alcohol use and the degree, severity, and freqency of battering incidents, Walker and Associates found that statistically 50% of the subjects had used alcohol excessively in each battering incident. When studying the individual batterer's drinking patterns, however, they found that the drinking behavior was inconsistent. The difference seems to be a change in the variables studied. In the final analysis, one-fifth of the batterers were found to use alcohol to excess during each of the battering incidents reported.[10]

During the 1980s, the mental health, social service, and victims advocacy field began to look at the needs of abusers for some kind of intervention. Batterers were referred by their partners or self referred to crisis lines and mental health centers in increasing numbers. Private psychotherapists and mental health counselors began trying to sort out treatment options for violent men while self-help groups like Batterers Anonymous and EMERGE were formed. The new trend in the literature was an analysis of the needs of batterers for treatment and how to approach that treatment. The Abusive Partner, edited by Maria Roy, includes a description of the group counseling format developed by the men's collective EMERGE.[11] David Adams, M.Ed. and Andrew J. McCormick, MSW, the authors of the piece, indicate that group counseling has been effective to end denial, build self-esteem, and find alternatives to using violence in their relationships. Others, such as Lenore Walker, David Sonkin, and Anne Ganley, agree.[12] Janet Geller, A.C.S.W., C.S.W., writing in The Abusive Partner, makes a case for conjoint therapy, in which both husband and wife are treated simultaneously. She believes that the batterer not only must face his violent behavior in counseling but will also be confronted with the effects of his violent behavior on his partner. Geller's view that couples counseling is the treatment of choice for violent partners is not widely held. Most victims advocates would disagree and assert that couples counseling has proven to be dangerous to the victim unless it occurs after the abuser has received individual treatment and changed his violent behavior. Lenore Walker believes that couples counseling has not been demonstrated to permanently end violent behavior. She further states, "Since each person has different needs, one therapist is often inadequate...I only recommend family or couples therapy when it is impossible to provide individual or group psychotherapy."[13]

Dr. Jeanne Deschner, Assistant Professor at the Graduate School of Social Work, University of Texas, proposes anger control training in her book, The Hitting Habit.[14] Deschner describes an anger control group she conducts for both parties in a violent relationship which includes the use of time outs, extensive assertiveness training, a weekly anger log, and educational components. According to Deschner, pre-treatment and post-treatment data were collected on twelve men and two women who completed a ten-week anger control group. Results showed that participants significantly decreased their anger and lessened their tendency to engage in verbal or physical aggression while increasing their tendency to stay calm and try to cope with a problem. Physical violence declined during the treatment period. Batterers were assaulting a family member on the average of once a month before

treatment. During treatment, one participant hit his wife on a single occasion. Follow-up had been accomplished with only two couples after one year, but there had been no resumption of violence in either relationship. Anger control is a component in many batterers programs across the country. Its weakness in this author's view is that it does not address the issues of socialization of sex roles, inequity of power in male/female relationships, or other psychosocial issues.

Anne Ganley and L. Harris, psychotherapists with the Tacoma Veterans Administration Center, designed and co-directed a residential treatment program for batterers in the Psychiatric Unit. Many had alcohol and drug problems or serious psychiatric problems. It became necessary for the therapists, because of the extent of the denial in the patients, to meet weekly with victims and other family members in order to get an accurate perception of the extent of the violence. Ganley continues to work with batterers and their victims though not in a residential setting. Although outcome data has not been published for the residential program, it is a concept which bears further consideration, especially in alcohol related family violence.

Very little useful data on long term results of batterers' treatment is available because most programs are only a few years old. AMEND (Abusive Men Finding New Directions) in Denver did a one-year follow-up study which revealed that 80% of the men that they treated were not behaving violently towards their mates. A Tacoma shelter-based program for batterers learned that 46 men who had attended their group sessions had stopped using physical violence (80% of the sample). Deschner points out that follow-up data on batterers is hard to collect because battering couples are highly mobile. It is also a reality that many programs have restricted budgets and lack the resources to do adequate follow-up. Many rely on voluntary contact.

It was interesting to this author that the literature on treatment of batterers made little mention of integrated treatment for alcohol abuse. Many do not mention it at all. Walker includes alcohol treatment as part of a list of "other" needed services. Only Janet Wright has extensively addressed the need for integrated services to chemically dependent batterers and the need for cross training among professionals in the family violence field and in the chemical dependency field. Her book, Chemical Dependency and Violence: Working with Dually Affected Families, is an essential cornerstone for designing viable intervention and treatment programs.

STATE OF THE ART INTERVENTION AND TREATMENT

There are as many opinions about intervention and treatment as there are counselors who serve men who batter. As previously noted, many do not confront the dual problem of alcohol abuse and battering. Relying on Janet Wright's model, I would like to propose the following intervention and treatment strategies:

1. Cross training for substance abuse counselors and family violence/batterers counselors.

   Wright's book is a useful tool for designing cross training. She suggests that cross training is a more cost effective method of confronting the problems of alcohol abuse and related battering because separate programs for each problem are usually operating in most communities. Further, the two separate agencies may identify a larger number of dually affected families.

   Wright further recommends that cross training includes experiential training in which the counselor actually spends time in the family violence program and the family violence worker spends time observing alcohol counseling or treatment. She says, "Experiential training is the cement of the training program. It helps the participants understand how the pieces fit together. It also greatly increases understanding between two staffs regarding the intricacies of their different jobs."[15]

2. Close coordination between family violence/batterers' programs and alcohol programs in working with dually affected families.

   It is clear to me that not a little denial has existed in both fields and that we have frequently offered token resources to dually affected families. It clearly is not enough for the shelter worker to tell the victim, "Your husband needs alcohol treatment" or to suggest Al-Anon as a resource for her. And it is not appropriate for the alcohol counselor to assume that the alcohol abuser's violent behavior will stop when he gets treatment.

   Cindy Friedman, Director of Pasadena's Haven House, a shelter program for battered women whose abusers are alcohol abusing, indicates that the program emphasizes <u>mandatory</u> attendance at alcohol education groups, <u>mandatory</u> Al-Anon meetings (2 or 3 times a week), and educational resources on chemical dependency and co-dependency.[16]

Coordination between programs should include:

a. Sharing referrals on a formal basis requiring both partners to allow release of information so that both agencies could monitor progress, confront when necessary, etc.

b. Educational programs for victims and abusers about the dual problem of alcohol abuse and partner abuse.

c. Inclusion in alcohol counseling and treatment programs of a specific component on family violence for violent men. Perhaps batterers' counselors could come into the substance abuse agency to provide this component.

d. Co-development of batterers' programs in communities where they do not exist.

3. Court mandated counseling:

In Washakie County, less than 1% of the batterers who agree to counseling follow through. Court-mandated counseling has been proven an effective means of dealing with both alcohol-related offenses and with spousal assaults. Education of the judiciary would be necessary but again might be accomplished cooperatively so that the need for alcohol treatment and batterers' treatment would be understood.

4. Residential alcohol treatment and aftercare:

For those who are chronic alcohol abusers and probably alcoholic, a residential alcohol treatment program is probably the most effective method of confronting and changing behavior.

Most alcohol treatment programs are four to six weeks in duration. It is recommended that the alcohol abuser have a good aftercare program which might include AA, an alcohol treatment group, or individual alcohol counseling (or all 3).

There is somewhat of a "chicken and egg" debate about what should come first: alcohol treatment or batterers' treatment. Because of the nature of chemical dependency, it seems clear that an alcohol dependent man will not be able to make real changes in his violent behavior until he is alcohol free. Again, it would seem most effective to include at least educational information around family violence in the alcohol treatment program and batterers' counseling included as a component of after-care.

5. Batterers' counseling:

Batterers' counseling appears to be most successful in a group setting, but can also be effective in individual therapy when it includes:

1. Assisting the abusing male to take sole responsibility for his violent behavior.
2. The problems in the relationship are not the initial focus -- the violence and abuse need to be confronted first.
3. Skill building for assertiveness, anger control, coping with stress, etc.
4. Ego building.

Janet Wright strongly recommends a group setting. Many experts agree.

6. Funding:

It is this author's belief that state of the art intervention and treatment will not occur in Wyoming until additional funding is available to develop cooperative educational and counseling programs, to develop viable batterers' programs in the state, and to do appropriate outreach to affected families.

I would like to encourage the Division of Community Programs to develop demonstration project grants or pilot projects in Wyoming for coordinating alcohol/family violence services.

PART II

ALCOHOL AND VICTIMS OF BATTERING

PROBLEM STATEMENT

Being physically and verbally abused by an intimate partner is one of the most painful experiences that a woman can have. In this country, it is estimated that half of the women will have that experience sometime in their lives. Anne Ganley likens battered women to prisoners of war because they experience similar disorientation, sleep deprivation, occasional malnutrition, and shock. Walker believes that battered women suffer from severe stress reactions. Anyone involved in women's advocacy can testify that battering is emotionally as well as physically destructive to an individual.

Some women are substance abusers when they enter a relationship with a violent partner. Others begin using substances to cope with the emotional and physical pain of being battered. Again, alcohol aids them in denying the seriousness of what is happening to them. Often, a woman will try to please her substance abusing mate by joining him in his favorite activity--usually with disastrous consequences. It is extremely difficult for a woman to free herself from the effects of a battering relationship because of many factors including traditional female roles, religious beliefs, emotional and economic dependence, and fear. The complication of an alcohol problem makes it much harder for that victim to get free.

It has been my experience that battered women with alcohol problems are extremely resistant to utilize resources available to them, including counseling, alcohol treatment, AA, or shelter. Perhaps part of the problem is that in many ways, help is offered but then snatched away. Most shelter programs do not open their doors to alcoholic victims because of the problems associated with communal living, because other victims have fled from homes where there is alcohol related violence, and because of inadequate resources to deal with alcohol problems. Some shelters will house alcoholic or alcohol abusing victims on the condition that they do not drink. For many alcohol dependent women in crisis, abstinence may seem like an impossibility.

Further, it is extremely difficult for alcohol abusing victims to get help from other helping agencies. There is still more stigma attached to being a female alcoholic than a male alcoholic.[18] The criminal justice, legal, and judicial systems particularly are judgmental towards victims who drink. It has been my experience that individual law enforcement officers view drinking as provocation for violent behavior on the part of the alcohol abusing victim's mate. They may be, therefore, reluctant to intervene appropriately. Even family and others who usually would be supportive to a victim of woman abuse may be judgmental and unhelpful to the substance abusing woman. This kind of "psychic battering" only tends to deepen the sense of blame and guilt that the alcohol abusing battered woman probably feels.

The need to develop programs which effectively serve and treat alcohol-abusing women is compelling. Those who work with victims see

clearly that alcohol abusing women are more seriously hurt in violent incidents because of the impairment in their perceptions and judgment and their ability to act in their own defense. Since we know that women are less likely to get treatment for substance abuse problems than men and that their alcohol dependency progresses more rapidly than that of male alcohol abusers,[18] it is evident that the alcohol abusing victim of violence should be targeted for aggressive identification and treatment. Further, we should all be concerned about continuing education of physicians, lawyers, judges, police, and other helpers--as well as the society at large--to remove the stigmas attached to alcohol problems and victimization by male violence.

ALCOHOL AND VICTIMS OF VIOLENCE: A REVIEW OF THE LITERATURE

Attention to the occurrence of alcohol problems in women who are battered is a relatively new phenomena. Certainly, victims advocates have known that some of their shelter clients were alcohol abusing but given the limitations of money and staff the focus was on issues of safety and systems advocacy. Experience has taught that alcohol dependent battered women are difficult to help and are the women who most frequently stay involved in violent relationships. What is known is that there are millions of battered women in this country and there may be as many as 8.5 million women with alcohol related problems.[19] It should not be surprising then that there is a substantial number of women who are experiencing both chemical dependency and battering.

Lenore Walker found that one-fifth of the 403 battered women she studied reported using alcohol during violent incidents. She also reports that few women admitted using drugs or alcohol during the thirty days prior to being interviewed but more did report use during acute battering incidents. Her study also showed that the alcohol abusing victim was more likely to be in a relationship with an alcoholic abusing batterer than were women who did not abuse alcohol.[20]

Marian Sandmaier in Alcohol Abuse and Women: A Guide to Getting Help[21] says that women drink primarily to relieve loneliness, inferiority feelings, and conflicts about their sex role, regardless of their life style. Langone and Langone stress that self-esteem is a key factor in women's drinking: "If she fails at what society has determined to be important (or what she perceives to be important), she has failed as a woman. Sometimes alcohol helps blot out that failure." They also suggest stressful life events and cultural expectations as contributing factors.[22] Certainly, low self-esteem, stereotypical sex roles, and stressful lifestyles are key elements in the lives of battered women.

Patricia McGuire points out that women are more likely to engage in hidden alcohol or other drug use because of the societal stigma placed on alcohol abuse by women. "Accordingly," she writes, "women have had a greater opportunity to progress to the advanced stages of chemical dependency before detection, and a greater motive for concealing and disguising their illness."[23]

A significant barrier to receiving treatment for alcohol abusing women is the issue of primary responsibility for the care of dependent children. This issue is particularly compelling in cases of family violence in which the abuser is violent towards the children or is not seen as an appropriate caretaker of the children while their mother receives treatment. Janet Wright points out that the alcohol abusing woman may fear losing custody if her alcohol problems are apparent.[24] In violent relationships, that fear is frequently reinforced by the batterer who continually uses the threatened loss of the children as a means to control his victim.

The alcoholic women having special problems around their chemical dependency and special needs for treatment are well documented. Several researchers into female alcohol abuse espouse individual therapy rather than group therapy (shown to be more effective for male substance abusers). Others, such as Jean Kirkpatrick, believe that groups restricted to women only are essential for effective treatment.[25] Self-help groups like AA and Women for Sobriety can be helpful and in communities where both are available, women have an opportunity to attend both and make a choice.

A handout from the Alcoholism Center for Women in Los Angeles identifies those at high risk for alcoholism as women who are adult children of alcoholics, incest or battering survivors, and lesbians. The Center believes that these groups account for up to 50% of all problem drinking women. Further, the Center believes that incest and battering survivors have alcohol abuse rates of 40-60%. Cindy Friedman of Haven House in Pasadena says that 20% of the women who come into the shelter program are determined to be alcohol abusing victims.[26]

Janet Wright and Judy Popham assert that the alcohol dependent victim of battering must resolve safety issues for herself and her children before she can concentrate on her chemical dependency. They believe that she should be in a shelter and referred for outpatient treatment while she makes plans for her children and resolves pressing legal issues. They further stress that the abuser cannot aid her in her treatment until he has confronted and changed his violent behavior. They also point out that a woman's substance abuse is not provocation or justification for physical abuse.[27]

STATE OF THE ART INTERVENTION AND TREATMENT

The first vital component in state of the art intervention and treatment is a better protocol for identifying dually affected victims of violence. Cindy Friedman agrees with this author that for years victims advocates had failed to identify alcohol abusing victims because they did not ask the right questions (again the focus was on retrieving information about the acts of abuse and identifying the woman's needs). Janet Wright urges that advocates ask every woman with whom they work about their drinking patterns. Similarly, substance abuse programs must include questions regarding family violence in their initial intakes and must not view incidences of family violence as merely symptomatic of alcohol abuse. The first recommendation, then, is:

1. Revision of intake and assessment materials for both family violence programs and alcohol programs to include direct questions about alcohol abuse and family violence respectively.

All the programs with which I spoke strongly urged education as a means of helping victims understand and identify their substance abuse problems. Haven House particularly includes extensive alcohol education programs and materials. Educational materials need to include information on chemical dependency and treatment and should be non-judgmental, empathic, and supportive.

2. Education components including:

   a. Educational pamphlets on women and substance abuse to be included in intake packets or to be readily available within the shelter or family violence office. (Please see addenda.)

   b. Posters in conspicuous locations within family violence programs regarding substance abuse and treatment options.

   c. Cross training between alcohol counseling, mental health, and family violence agencies.

The last recommendations involve programmatic and treatment options:

3. A change in the policy of most Wyoming shelters to include substance abusing victims in the shelter population with the following provisions:

a. The victim not consume alcohol or other drugs while in residence and the understanding that she may be asked to leave if she does so.

b. That the alcohol abusing resident be required to begin outpatient alcohol treatment and/or attend AA while she is in residence.

c. That the resident seriously consider her options for inpatient treatment with the understanding that she can return to the shelter setting after treatment if necessary.

4. That the Division of Community Programs give serious consideration to the development of residential treatment facilities where women can bring their dependent children.

   According to Cindy Friedman, the trend toward family residential treatment centers is growing in California. There are three such facilities in the Los Angeles area. Space is limited to 9-16 women and their children thus eliminating a significant barrier to getting residential treatment.

5. That, wherever possible, groups for woman abusers only be developed and implemented. Perhaps this is an area where family violence programs, which are already required to run support groups for women, and substance abuse programs could function in cooperation.

6. That the Division of Community Programs require, as part of its standards for mental health centers, alcohol treatment programs, and family violence programs, that these involved agencies trade referrals. In other words, when the alcohol counselor learns that there is family violence in the alcohol affected family, he or she must refer that family to the family violence program. Similarly, the victim advocate who learns that there is an alcohol problem with either victim or abuser would be required to refer to an alcohol counseling program.

7. Finally, it is crucial that all involved agencies conduct a public education program in order to increase the public's understanding of the dynamics of chemical dependency and of family violence in order that a more favorable environment in which men and women can seek recovery will be created.

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PART IV

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PART V

ADDENDA

LOCAL STATISTICS: AN ANALYSIS

In October 1984, Community Crisis Services changed its intake form to include specific questions about alcohol and other drug abuse among victims and their abusers. Since that time, 40 women have been sheltered. The compiled statistics are:

- 32 out of 40 women reported abusers had drinking problems (85%).
- 3 out of 32 reported abusers also abused other substances (8% of total).
- 1 out of 40 reported that her abuser used drugs other than alcohol (3%).
- 6 out of 40 women were identified as problem drinkers (15%); only 1 self-reported (3%).
- Of the six who had drinking problems, 100% were involved with alcohol and other substance abusing batterers.
- Of the 6 who had alcohol problems, 5 requested shelter or other services at least twice (83%).
- Of the 6, 3 are living with abusers; 3 are separated or divorced (50%). Of the 3 still living with abusive partners, 1 is not being abused (33%).
- Of the 6, only 2 sought professional intervention specific to alcohol abuse; only 1 successfully completed alcohol counseling or attended AA.
- Of the 6, 3 sought mental health counseling specific to family violence (50%); currently all 3 are still in counseling (2 years 7 months, and two weeks duration).
- Of the 6, only 1 (3%) drank while in the shelter setting.

FROM ALCOHOLISM CENTER FOR WOMEN

WHO IS AT HIGH RISK?

Women at high risk for alcoholism include, but aren't limited to, ADULT CHILDREN OF ALCOHOLICS, INCEST OR BATTERING SURVIVORS, AND LESBIANS. These groups represent at least 25% of women who drink and up to 50% of all problem drinking women.

There are 25-28 million children of alcoholics in the U.S. who have 40-60% rates of alcoholism. Those who don't develop a drinking problem are more likely to establish problematic relationships with alcoholics, other compulsive persons, or other children of alcoholics.

Incest and battering are correlated with alcoholism in two ways. First, 30% of father-daughter incest and 75% of domestic violence is alcohol-related. Second, incest/battering survivors also have alcohol abuse rates of 40-60%.

25-35% of the lesbian and gay community has a serious drinking problem; at least 30% are closely involved with a problem drinker.

Victims of rape or other violent crimes also frequently turn to alcohol or other drugs to cope with pain, fear, feelings of powerlessness and alienation, and often the withdrawal of support from family and friends.

This is not a comprehensive list of of all women at risk for alcohol abuse and a woman does not need to identify with any of these populations to become alcoholic. However, these groups share three common characteristics that are compatible with the development of alcohol-related problems: long-term denial, stigma, and a sense of alienation from both family and community.

Children of alcoholics, even from the same family, respond differently to the environments they grew up in. However, the feelings are much the same. Common areas of concern include low self-esteem; preoccupation with the needs, feelings, and judgements of others; fears of abandonment; distrust of self and others; and chronic depression. Incest/battering survivors often feel responsible for the abuse, guilty, ashamed, helpless, and alone in their pain. For both populations, drinking may provide a way to escape from pain and guilt, to self destruct, or both. Three factors contribute to alcohol abuse among lesbians. Alcohol may serve as a temporary coping tool for living in a heterosexual, often hostile, world; the lesbian bar remains a traditional place to socialize; and alcoholism services often lack responsiveness to lesbian clients.

Our society is slow to recognize issues relating to alcoholism, child abuse, and homophobia. We can all help break the silence. Women at high risk for alcoholism <u>can</u> arm themselves against (or find their way out of) the trap of alcohol abuse.

WHAT CAN WOMEN AT HIGH RISK DO?

If you relate to these issues, you are a survivor; you can do more than survive, you can thrive. Survivors can emerge from confusion, loss, and pain to build whole and happy lives. Those of us who have struggled with denial, stigma, and alienation - and won - continue to grow. We strive to live full lives, reach out to others who still suffer, or even step forward to dispell some of the myths that we, at one time, internalized. We grow by looking at our hurts and anger, learning to nurture ourselves, discovering new coping skills, and by building support networks. Support may be found through self help groups, individual or group therapy, new friends, groups working for social change, or a combination of these.

Many individuals and organizations offer help, support, and information. The ALCOHOLISM CENTER FOR WOMEN is one. We are a non-profit, community based agency with over 10 years of experience serving women with alcohol related problems and women at high risk. We are funded in part by the L.A. County Alcoholism budget and offer our services through four components: a 15 bed residential recovery home, a full-time day or part-time out-participant program, a re-entry home for recovering women and their children called New Journeys, and our Prevention Services.

Can women like that really be helped?

It is important for anyone interested in helping battered women who are also chemically addicted to explore their own attitudes. If one sees them as "women like that," one is already making a judgment as to their human worth. Only by attempting to keep an open mind to the complexities of the female addict's life situation, including the implications of a very real possibility of incest, emotional deprivation, and a long history of sexual and physical abuse, can one begin to be helpful.

This brochure was developed through a grant from the North Dakota State Department of Health, Division of Alcoholism and Drug Abuse, to the Abused Women's Resource Closet, Bismarck, N.D.

It was printed by the State Networking Office of the N.D. Council on Abused Women's Services, ~~311 E. Thayer Avenue #127~~, 418 E. Rosser #210, Bismarck, N.D. 58501.

701 255 6240

BEST COPY AVAILABLE

alcohol, drug abuse, and battered women

How often is alcohol and drug abuse involved in battering situations?

Very frequently, even though no private or governmental research has proven that alcohol or drug abuse in and of itself causes violence against women.

If it is so frequently present, why hasn't the connection been proven?

People have made alot of assumptions about alcohol and abusive behavior without asking very many questions. Addiction counselors and therapists have generally not asked about or dealt with abuse, and crisis intervenors have just begun to ask about the drinking patterns of both partners.

For example, many violent episodes are carefully planned in advance and carefully directed only toward household members -- car keys are hidden, children sent to a neighbor. Considering that this kind of premeditated, selective violence requires alot of self control, we should be asking, "Why does the violent alcoholic have so much control on one hand and apparently so little on the other?" Also, "Why is it a wife, a female lover, or a child more often the target of violence than a neighbor, a boss or a friend?" And, "Are there long-standing, unresolved problems with sexuality which result in the equation of sex, violence and love, and thus result in violent abuse?"

But if he stops drinking or using drugs, doesn't the violence usually stop?

Sometimes it does, although in a certain percentage of cases, women have reported that the violence has actually increased after he stopped drinking.

The point is, as any active AA member knows, recovery from alcoholism demands a total life change, including changes in attitudes towards one's self, one's spouse, children and others.

Restraining oneself from drinking or abusing drugs is an essential step for recovery, but not the only step. Working through sexual problems and relationships with the opposite sex is also an essential part of total recovery. If this work is not done, sexual, emotional or psychological abuse often continues, even though the physical abuse stops.

Some women are such nags or prudes, don't they drive their husbands to drink and beat them up?

No one can force another person to drink or to beat them up. The alcoholic is responsible for choosing to drink and for his/her own behavior while drinking or sober — with people who are polite and kind, and with people who are obnoxious and insulting.

But what if she drinks or uses drugs with him? Isn't that playing with fire?

Yes, it is a dangerous thing to do because battered women are high risk candidates for alcohol and drug abuse, and it is becoming increasingly apparent that victims of battering are also frequently victims of alcohol and/or drug abuse. Many begin their addiction with drugs prescribed "for their nerves." When the drugs are no longer enough by themselves, they begin to use alcohol also.

Other battered women are intimidated into drinking to prevent a beating. Of course, this is a mistaken notion; the husband who threatens to beat his wife because she is "such a holier than thou prude", once she has drunk enough, can, and often does, beat her because she is a "no good drunken slut."

Once the battered woman realizes she is in this double bind, she may begin to drink simply to ease the pain — both the physical and emotional pain — of being battered.

So by continuing to drink isn't she asking to be beaten?

No one asks to be beaten. No one deserves to be hurt or humiliated. If she has become addicted to alcohol and/or drugs, she has a serious problem which must be dealt with. Her addiction does not make her any less human or any less deserving of respect, however, even though there is a heavy stigma on the female alcoholic.

It is ironic and therefore difficult for some people to understand that even the female alcoholic who becomes boisterous, brash, and insulting is not engaging in this kind of behavior in order to set herself up for a broken nose or a black eye, even though that is often the very real, short term result of her behavior. On the contrary, she is attempting to communicate her need for security, for love, for honest human relationships. Unfortunately, she is "asking for" these things in a very inappropriate and self-destructive way which will only drive them further away. Nevertheless, it is warmth and freedom from loneliness and depression she wants and needs, not a slap in the face.

Alcohol and pills are the only things that have ever helped me survive. What can I do to live without them?

You need to do two things. First, make an honest assessment of your own chemical dependencies. If you are addicted, you will need outside help to recover.

At the same time you are assessing the seriousness of your drinking and pill taking, make an honest assessment of your relationship with your abusive partner. If you have been living in an abusive situation, you will need help to recover from that abuse as well.

And remember —

There are people who can help.

For more information,
referrals,
someone to listen:

Call:
1-800-472-2911
Mental Health Association of
North Dakota
Toll-free Hotline

This brochure was developed through a grant from the North Dakota State Department of Health, Division of Alcoholism and Drug Abuse, to the Abused Women's Resource Closet, Bismarck, N.D.

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701-255-6240

DOUBLE TROUBLE

for BATTERED WOMEN who use ALCOHOL and DRUGS

WOMEN, ALCOHOL & DRUGS: SOME GENERAL FACTS

More women are drinking, and more women are becoming alcoholics. Surveys in recent years first revealed that for every three male alcoholics, there was one female; then the statistics changed to one for every two; and, most currently, estimates are that there may be one female alcoholic for every male who is addicted.

We are just beginning to learn who the female addict is and what might make her different from her male counterpart. We do know that —

- chemically dependent females suffer from depression far more often and far more severely than males.
- female addicts usually become addicted later in life and often as a result of a significant "life stress" such as death of a spouse or child. (Or, possibly, a physically abusive situation.)
- women are much more frequently "cross-addicted" (abusing both drugs and alcohol) than men.
- a high percentage of chemically dependent women have been victims of incest or other sexual abuse.

What does this have to do with battered women?

Women in general are in a high risk group for receiving prescription drugs. Within the general population, we are about 2½ times more likely to receive prescriptions than men.

Women living in high stress situations are even more likely to be given drugs "for their nerves." Living with an abusive spouse is a very high stress situation, and the battered woman is especially vulnerable to turning to drugs and/or alcohol to cope.

But if my doctor prescribed a drug, isn't that OK?

Many physicians have chosen not to deal with the reality of physical abuse and minimize its importance by treating it as the "woman's problem" and "a case of nerves." The solution — tranquilizing drugs.

It is important to point out that most of the drugs abused in this country are legally prescribed. Most of the people who abuse these drugs are women.

But I'm not sure I could cope without my pills. I don't take that many.

Drugs and alcohol mask symptoms, they do not help us deal with the cause of our problems. One of the frightening things about abuse is that it escalates. Drugs and alcohol reduce our capacity to assess our own danger and the danger to our children and even to the batterer. Therefore, if we are using drugs to avoid dealing with the problem of abuse, we may pay dearly for the diversion, even if we never become addicted.

I sometimes have a few drinks with my husband. Sometimes I want to; sometimes he insists. Is that bad?

The question is not whether it is "good" or "bad." The fact remains, it is dangerous. If you are living in a violent and abusive situation, drinking alcohol becomes a dangerous game of roulette. If you are also taking drugs of any kind, it could be lethal.

As far as your husband's "insisting" you drink with him, why do you think he needs you to drink with him so desperately? It may be a danger sign that should alert you to *his* vulnerability to alcoholism.

A PERSONAL INVENTORY

- ☐ Are you taking prescribed drugs in order to cope with abuse at home?
- ☐ Do you sometimes feel the pills alone are not enough and "boost" them with alcohol?
- ☐ Do you sometimes drink with your spouse, even when you don't want to, in order to prevent a beating?
- ☐ Are you or have you been involved with illegal drugs in order to cope with abuse?
- ☐ Does the thought of continuing to live in your present situation without the help of alcohol or drugs seem overwhelming and frightening?